CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, person, partnership, corporation, or association that is Medicare certified by the Virginia Department of Health and has a current, signed participation agreement with the Department of Medical Assistance Services.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. A copy of the provider agreement can be found within this chapter. Providers must sign the appropriate Participation Agreement and return it to the First Health Provider Enrollment Unit; an original signature of the individual provider is required.

To become a Medicaid provider of services, providers must obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients.

Upon receipt of the above information, a provider number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid. Each provider is furnished a manual containing instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by writing, calling, or faxing their request to:

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medicaid Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify the First Health Provider Enrollment Unit, in writing, of any change in the information which the provider previously submitted.

- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.

- Assure the recipient's freedom to reject medical care and treatment.

- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, or national origin.

- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations are made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to section regarding the Rehabilitation Act).

- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept as payment in full the amount established by the Department to be reasonable cost or maximum allowable charge. 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." The provider should not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Medicaid Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

  Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to section regarding documentation of records.)
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.
- Hold confidential and use for authorized department purposes only all medical assistance information regarding recipients. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. The state agency shall not disclose medical information to the public.

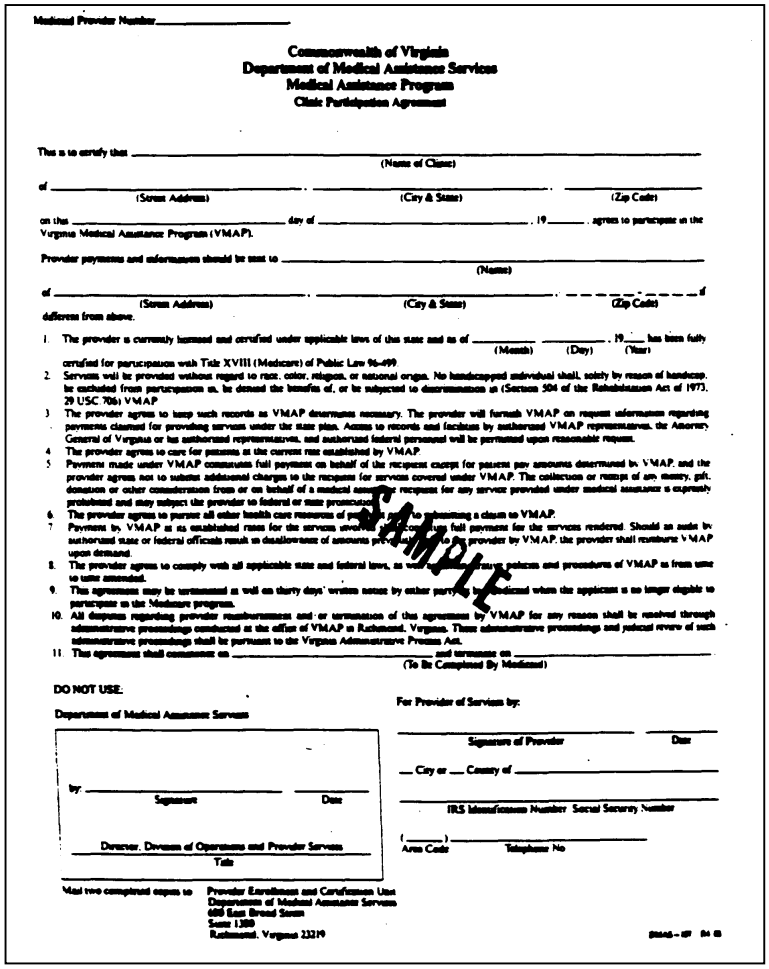
PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. A freestanding renal dialysis center is eligible for participation in the Department of Medical Assistance Services program if the clinic is Medicare certified by the Virginia Department of Health, Division of Licensure and Certification, as meeting the conditions for participation under Title XVIII of Public Law 89-97.

A sample copy of the clinic participation agreement is provided in Exhibit II.1.

EXHIBIT II.1

CLINIC PARTICIPATION AGREEMENT, DMAS-107



Medicaid Provider Number _____

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Clinic Participation Agreement

This is to certify that _____ (Name of Clinic)

of _____ (Street Address) _____ (City & State) _____ (Zip Code)

on the _____ day of _____, 19____, agrees to participate in the Virginia Medical Assistance Program (VMAP).

Provider payments and information should be sent to _____ (Name)

of _____ (Street Address) _____ (City & State) _____ (Zip Code) if

different from above.

1. The provider is currently licensed and certified under applicable laws of the state and as of _____ (Month) _____ (Day), 19____ (Year) has been fully certified for participation with Title XVIII (Medicare) of Public Law 96-499.
2. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973, 29 USC 706) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The provider agrees to care for patients at the current rate established by VMAP.
5. Payment made under VMAP constitutes full payment on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.
6. The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved [illegible] full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts paid to the provider by VMAP, the provider shall reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as [illegible] service policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on thirty days' written notice by either party [illegible] when the applicant is no longer eligible to participate in the Medicare program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. This agreement shall commence on _____ and terminate on _____ (To Be Completed By Medicaid)

DO NOT USE:

Department of Medical Assistance Services

by: _____ Signature _____ Date

_____ Director, Division of Operations and Provider Services
Title

Mail two completed copies to: Provider Enrollment and Certification Unit
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia 23219

For Provider of Services by:

_____ Signature of Provider _____ Date

___ City or ___ County of _____

_____ IRS Identification Number/ Social Security Number

(____) _____ Area Code / Telephone No

DMAS-107 84 IB

SAMPLE

CERTIFICATION AND RECERTIFICATION

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or order health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice and economic considerations.

Physicians, General

Medicaid recognizes the physician as the key figure in determining utilization of health services. The physician decides upon admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. The Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished, and, in certain instances, only if there is a physician's recertification to the continued need for the covered services.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by endorsement, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medicaid Program is a "last pay" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by workers' compensation.

- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries** - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medicaid Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Code of Virginia, Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

  In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. A copy of this form is presented on the following page (Exhibit II.2).

DOCUMENTATION OF RECORDS

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are required:

- The record must identify the patient on each page.

EXHIBIT II.2

THIRD-PARTY LIABILITY INFORMATION REPORT, DMAS-1000

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87

- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.

- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every clinic visit billed to Medicaid.

- All laboratory tests billed to Virginia Medicaid must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests are to be documented by positive or negative. Those laboratory services requiring descriptive results are to be fully documented. Documentation examples are listed below:

  Quantitative tests:
  WBC - 7,000/mm^3
  Glucose - 85 mg/100 ml

  Qualitative tests:
  Monoscreen - positive
  Pregnancy test - negative

  Descriptive tests:
  Urine microscopy - clear, yellow-brown, few wbc, rare renal epithelial cell
  Urine culture - greater than 10^5/ml E. coli

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION
[Effective Date: January 23, 1992]

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the Physician Manual.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no

billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate his participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination should be made to the Director, Department of Medical Assistance Services and First Health Provider Enrollment Unit.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 15 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 9-6.14:1 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to the Code of Virginia, Section 32.1-313.1. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms, not to exceed 24 months.